MDR Tracking Number: M5-04-3816-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-06-04.

The IRO reviewed therapeutic exercises, office visits, manual therapy technique, chiropractic manipulative treatment, electrical stimulation-unattended rendered from 07-08-03 through 04-29-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

The IRO determined that treatment and services from dates of service 07-08-03 through 08-18-03 **were** medically necessary. The IRO determined that services from 08-20-03 through 04-29-04 **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-29-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

EOB's were not submitted for CPT code 97110 dates of service 07-09-03 and 08-18-03. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD)

has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code 99212 for dates of service 08-13-03, 08-15-03, 08-18-03 and 08-20-03. Review of the reconsideration HCFA's reflected proof of submission. The disputed services are reviewed according to the Medical Fee Guideline effective 08-01-03. Reimbursement is recommended in the amount of $167.64 ($41.91 X 4).

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code 97140-59 for date of service 08-13-03. Review of the reconsideration HCFA's reflected proof of submission. The disputed services are reviewed according to the Medical Fee Guideline effective 08-01-03. Reimbursement is recommended in the amount of $30.90.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code 98940 for date of service 08-20-03. Review of the reconsideration HCFA's reflected proof of submission. The disputed services are reviewed according to the Medical Fee Guideline effective 08-01-03. Reimbursement is recommended in the amount of $30.14.

CPT code 99080-73 date of service 04-23-04 denied with denial code U. This service is a TWCC required report and will therefore be reviewed as a fee issue. The requestor did not submit relevant information to support delivery of service. No reimbursement is recommended.

Total reimbursement for the **fee** issues is recommended in the amount of **$228.68.**

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 07-08-03 through 04-23-04 in this dispute.

This Findings and Decision and Order are hereby issued this 5th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

August 26, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-3816-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, operative and radiology reports.
Information provided by Pain Management Specialist: office notes and operative reports.
Information provided by Spine Surgeon: office notes.

Clinical History:
The records indicate the patient was originally injured on ___. Due to ongoing problems, he underwent low back surgery consisting of removal of hardware in May of 2003. He participated in therapy. On 10/8/03, the patient received a fusion of the right SI joint. Therapy was begun on 4/23/04. This lasted until 9/24/03 with a total of 30 sessions.

Disputed Services:
Therapeutic exercises, office visits, manual therapy technique, chiropractic manipulative treatment, electrical stimulation-unattended during the period of 07/08/03 through 04/29/04.

Decision:
The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that all treatment and services in dispute as stated above were medically necessary from 07/08/03 through 08/18/03 were medically necessary. All treatment and services in dispute as stated above from 08/20/03 through 04/29/04 were not medically necessary in this case.

Rationale:
National treatment guidelines allow for this type of treatment for these types of injuries, however, not to the intensity, frequency, and duration this patient received for the surgical removal of hardware. Normal guidelines allow for 6-8 weeks of treatment. There is nothing in the records that would indicate this patient needed more than eight weeks of postoperative rehab to recover. The SI joint fusion was performed on 10/8/03. The denied dates of services from 4/23/04 through 4/29/04 are over six months after the SI joint fusion. No treatment guidelines allow for this type of treatment 6 months after the fusion. In conclusion, all denied services from 7/8/03 through 8/18/03 were in fact reasonable, usual, customary, and medically necessary for the treatment of this patient's on the job injury. All denied services from 8/20/03 through 4/29/04 were not medically necessary.